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## External Appeals

### Sec. 38a-478n-1. Applicability and scope

Nothing in Sections 38a-478n-1 to 38a-478n-5, inclusive, shall be construed to apply to:

(a) the arrangements of managed care organizations offered to individuals covered under self-insured employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974; or

(b) any plan that provides for the financing or delivery of health care services solely for the purposes of workers' compensation benefits pursuant to chapter 568 of the general statutes.

(Adopted effective December 24, 1997)

### Sec. 38a-478n-2. Definitions

As used in Sections 38a-478n-1 to 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies:

(a) "Adverse determination" means a determination by a utilization review company or managed care organization not to certify either before, during, or after services are received an admission, service, procedure or extension of stay because, based upon the information provided, the request does not meet the utilization review company or managed care organization's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

(b) "Business Day" means a day during which the state government of Connecticut conducts regular business;

(c) "Commissioner" means the Insurance Commissioner;

(d) "Department" means the Insurance Department;

(e) "Enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents who participate in a managed care plan. For purposes of pursuing an appeal only, the term "enrollee" shall include any person the enrollee has designated as his or her legal representative;

(f) "External appeals entity" means an impartial health entity, selected by the commissioner, after consultation with the commissioner of Public Health to provide a binding decision in cases where all internal appeals within a licensed utilization review company or managed care organization have been exhausted;

(g) "Indigent individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, as certified by the individual on a form provided by the commissioner, from the most recent federal tax return filed is less than two hundred percent of the applicable federal poverty level;

(h) "Internal appeals" means the procedures provided by the utilization review company or managed care organization in which either the enrollee or provider acting on behalf of an enrollee may seek review of decisions not to certify an admission, procedure, service or extension of stay;

(i) "Managed care organization" means "managed care organization" as defined in section 38a-478(2) of the Connecticut General Statutes;

(j) "Managed care plan" means "managed care plan" as defined in section 38a-478(3) of the Connecticut General Statutes;

(k) "Provider" means a person licensed to provide health care services of the type specified in chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, of the Connecticut General Statutes, or chapter 400j of the Connecticut General Statutes;

(*l*) "Provider of record" means the physician or other licensed practitioner identified to the utilization review company or managed care organization as having responsibility for the care, treatment and services rendered to an individual;

(m) "Utilization review" means "utilization review" as defined in section 38a-226 of the Connecticut General Statutes; and

(n) "Utilization review company" means "utilization review company" as defined in section 38a-226 of the Connecticut General Statutes.

(Adopted effective December 24, 1997; amended August 30, 2004)

### Sec. 38a-478n-3. External appeals

(a) Any enrollee, or any provider acting on behalf of an enrollee with the enrollee's consent, who has exhausted the internal mechanisms provided by a managed care organization or utilization review company to appeal the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner.

(b) To appeal a denial or determination pursuant to this section an enrollee or any provider acting on behalf of an enrollee shall, not later than thirty (30) days after receiving final written notice of the denial or determination from the enrollee's managed care organization or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the filing fee set forth in section 38a-478n of the general statutes, and a general release executed by the enrollee for all medical records pertinent to the appeal. The managed care organization or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in section 38a-478n of the general statutes. The commissioner shall waive the filing fee, on request, for individuals who demonstrate that they are indigent or unable to pay.

(c) For the purposes of sections 38a-478n-1 to 38a-478n-5, inclusive, of the Regulations of Connecticut State Agencies, not later than five (5) business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization whose enrollee is the subject of an appeal shall:

(1) provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's managed care plan is fully insured, self-funded, or otherwise funded, and

(2) If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization shall send: (A) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization, except that with respect to a self-insured governmental plan, (i) the managed care organization shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization to send, such copy; or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy.

(d) The commissioner shall assign the appeal to an external appeals entity for review. In making such an assignment the commissioner shall consider the level of expertise of the entity to review the particular procedure or service for which the certification was denied. The commissioner may consider recommendations regarding the choice of an appropriate entity for an appeal.

(e) Within five (5) business days of receipt of the request for appeal from the commissioner, the external appeals entity shall conduct a preliminary review of the appeal and accept it for full review if it determines that:

(1) the individual was or is an enrollee of the managed care organization;

(2) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service or benefit under the agreement provided by contract to the enrollee and any benefit limitations have not been exhausted;

(3) all internal appeals have been exhausted; and

(4) the appeal includes all information required by the commissioner.

(f) Upon completion of the preliminary review, the external appeals entity shall notify the commissioner, and the enrollee or provider of record, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons therefore. If the appeal is accepted for full review, the entity shall immediately notify either by facsimile machine or by overnight service, the enrollee or provider of record and the managed care organization or utilization review company of their opportunity to submit the information specified in subsection (g) of this section within five (5) business days from the date of such notice for consideration during its review.

(g) Upon acceptance of the appeal for review, the external appeals entity shall conduct a full review to determine whether the adverse determination should be reversed, revised, or sustained. Such review shall be performed by a provider who is a specialist in the field related to the condition that is the subject of the appeal. The reviewing provider may take into consideration:

(1) pertinent medical records,

(2) consulting physician reports,

(3) practice guidelines developed by the federal government, national, state or local medical societies, boards or associations, and

(4) clinical protocols or practice guidelines developed by the utilization review company or managed care organization.

(h) The external appeals entity shall complete its review and forward its decision to affirm, revise, or reverse the adverse determination to the commissioner within thirty (30) business days of completion of the preliminary review together with a report of its review. The external appeals entity may request an extension of time from the commissioner within which to complete its review as may be necessary due to circumstances beyond its control. If an extension is granted, the external appeals entity shall provide written notice to the enrollee or provider, setting forth the status of its review, the specific reasons for the delay and the anticipated date of completion of the review.

(i) The commissioner may reassign an appeal to another external appeals entity if the commissioner determines (1) that a conflict of interest exists which may negatively impact the objectivity of the entity to which the appeal was initially assigned or (2) that the entity to which an appeal was assigned is unable to complete its review within a reasonable time.

(j) The commissioner shall accept the decision of the external appeals entity and notify the enrollee or provider and the utilization review company or managed care organization of the decision, which shall be binding. The report of the external appeals entity's review shall be made available to the enrollee or provider and the utilization review company or managed care organization. The decision of the external appeals entity shall not be construed as authorizing services in excess of those that are provided for in the enrollee's managed care plan.

(k) The request for appeal submitted by the enrollee or provider of record, the associated materials received by the managed care organization or utilization review company, the decision of the external appeals entity, and communication by and between the commissioner, the external appeals entity and the enrollee shall be maintained as confidential information protected by section 38a-8 of the Connecticut General Statutes.

(Adopted effective December 24, 1997; amended August 30, 2004)

### Sec. 38a-478n-4. External appeals entities

(a) The commissioner shall enter into agreements for external appeals services with as many external appeals entities as he deems necessary after consultation with the Commissioner of Public Health. The agreements shall set forth all terms which the commissioner deems necessary to assure a full and fair review of appeals. Selection of an external appeals entity shall include, but not be limited to, review of the entity's application with regard to the following:

(1) proposed scope of services;

(2) fee structure;

(3) number and qualifications of reviewers;

(4) procedures to ensure the confidentiality of health care information;

(5) procedures to ensure the neutrality of reviewers;

(6) administrative and operational policies and procedures; and

(7) procedures to ensure that no conflict of interest exists among the entity and its reviewers and managed care organizations or the case under review.

(b) After entering into an agreement with the commissioner, the entity shall report changes in its ownership, operational or administrative status to the commissioner within thirty (30) days of the effective date of such change. If the commissioner determines that the reported change(s) may negatively impact the effectiveness or objectivity of the external appeals entity, the commissioner reserves the right to terminate the agreement.

(c) Any agreement may be terminated without cause by either party upon ninety (90) days written notice, except that the commissioner may terminate an agreement with an external appeals entity at any time if the commissioner determines that continuation of the agreement may result in unfair, biased or unreliable determinations which pose a threat to the public health.

(Adopted effective December 24, 1997)

### Sec. 38a-478n-5. Separability

If any provision of Sections 38a-478n-1 to 38a-478n-4, inclusive, or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of these regulations, and the application of such provision to other persons or circumstances, shall not be affected thereby.

(Adopted effective December 24, 1997)